Response to HCFA Questions Received 7-2-99
Alabama Medicaid Request for an 1115 Family Planning Waiver
Response Date: 10-8-99

ACCESS TO SERVICES

(1) What are the barriers against the use of family planning services by eligible postpartum women **(p.** 8).?

As stated on p. 7, only a small portion of low-income women within the state has access to Medicaid or private insurance coverage for family planning." As noted on p. 7, Alabama has one of the highest rates of uninsured adults in the nation. The major barriers to utilization of family planning services are discussed on p. 7 & 8 of the proposal. The Alabama Medicaid Program currently provides coverage for family planning services to only three groups of childbearing women:

1. *Women eligible for health care under Medicaid for Low-Income families.*
2. *Women who fall under 133% of the federal poverty level who are covered for familyplanning services for 60 days following delivery.*
3. *Women who are eligible for SSI.*

Some of the barriers to effective family planning include the waiting list for sterilizations for currently uninsured women, general lack of education on contraception, misunderstanding of how to appropriately uge the chosen contraceptive method, and transportation. The need for ongoing contraception and planning for pregnancy is an essential message that must be understood by the target population in order to make strides in reducing unintended pregnancy rates.

(2) What percent of low-income women have access to Medicaid or private insurance coverage for family planning (p. 7)?

According to a survey conducted for the Urban Institute, approximately 64.4% of nonelderly adults under 200% of poverty in Alabama are insured, either privately or publicly.
(See table below, which can also be viewed at
http://newfederalism.urban.org/nsaf/tables/health b2.htm .)

Nonelderly Adults Covered by Health Insurance, 1997
(Percent estimates and standard errors)

Type of Insurance		AL	CA	CO	FL	MA	MI	MN	MS	NJ	NY	TX	WA	WI	US
Under 200% of poverty															
Privately Insured	Percent	46.5	**35.0**	**47.7**	44.1	44.5	**50.1**	**53.3**	41.1	46.8	**38.2**	**35.9**	43.7	**58.0**	43.5
	Standard error	1.7	1.6	1.7	2.1	2.0	1.7	2.1	1.6	2.1	1.4	1.4	1.6	1.7	0.7
Publicly Insured	Percent	17.9	22.0	**14.4**	**16.5**	**25.3**	21.5	**25.7**	22.1	19.8	**27.2**	**14.2**	**25.9**	**14.1**	19.9
	Standard error	1.4	1.3	1.3	1.3	1.5	1.4	1.6	1.3	1.5	1.6	1.1	1.4	0.8	0.6
Uninsured	Percent	**35.6**	**43.1**	**37.9**	39.5	**30.2**	**28.4**	**21.0**	**36.8**	**33.4**	**34.7**	**50.0**	**30.5**	**27.9**	**36.6**
	Standard error	1.7	1.7	1.7	2.3	1.8	1.4	1.7	1.4	2.0	1.8	1.6	1.4	1.5	0.7
Over 200% of poverty															
Privately Insured	Percent	88.3	86.3	86.9	**83.2**	**91.0**	**92.6**	**91.5**	86.1	**90.1**	89.9	**82.1**	86.3	**93.7**	88.0
	Standard error	1.2	1.0	0.8	1.3	0.8	0.9	0.7	1.3	0.7	1.0	1.4	0.8	0.5	0.4
Publicly Insured	Percent	3.6	4.1	**4.6**	5.3	**2.2**	**1.6**	2.7	**5.2**	**2.0**	**2.1**	3.8	**5.8**	**1.5**	3.3
	Standard error	0.7	0.7	0.5	0.8	0.4	0.3	0.4	0.8	0.3	0.5	0.7	0.6	0.2	0.3
Uninsured	Percent	8.1	9.6	8.5	**11.5**	**6.8**	**5.8**	**5.8**	8.7	7.9	8.0	**14.1**	8.0	**4.8**	8.7
	Standard error	1.0	0.9	0.6	1.3	0.8	0.9	0.6	1.0	0.6	0.8	1.3	0.6	0.5	0.3
Source: Urban Institute															

Information added after conference call

Determination of the number of women with private insurance is difficult. It is even more difficult to determine whether or not the policies of women with insurance covers family planning. Perhaps the percent of SOBRA women with private insurance can be used to estimate the number of women with private insurance with family planning coverage. Currently, it is estimated that less than 50% of poverty level women with Medicaid paid deliveries had private insurance. Please note that if a woman is enrolled in the Medicaid program, Medicaid requires that third party insurance be filed prior to Medicaid making a payment for direct patient care.

Set 2 (1) Please explain the chart from the Urban Institute which was utilized as a response for Question Two which relates to the percentage of low-income women who have access to Medicaid or private insurance coverage for family planning services.

The chart was included to demonstrate the kind of insurance information that is available. The state has been unsuccessful in locating statistics specific to family planning.

(3) Please clarify who is included in the target population (p.11). The application states that 126,079 will be eligible including female teens, but the waiver does not include teens. What is the estimated number of women age 19 to 44 under 133% of poverty in Alabama?

*The number of eligibles you refer to on p.11 is a count of the total female beneficiaries of **any** age who would be eligible for Medicaid family planning benefits in the absence of the waiver. Of that number only 90,796 are in the age range 19-44 years (the same age as the target population for this waiver).*

*You are correct in that the only teens in the waiver are the 19-year-olds. We estimate that there will be 201,517 women aged 19-44 under **133%** of the FPL in Alabama in the first year of the waiver (2000). Of that number 90,796 are already enrolled in Medicaid. This leaves a target population of approximately 111,000 women aged 19-44 years with incomes below **133%** of the FPL, who are not already enrolled in Medicaid.*

(4) Prior to implementation of the 1115 program, what is the plan to address the lack of transportation and limited distribution of providers that are currently barriers to the utilization of family planning services by eligible beneficiaries?

Lack of transportation has traditionally been problematic for low-income populations. Medicaid's Non Emergency Transportation Program has proven to be extremely beneficial to Medicaid beneficiaries and as a result has lessened the burden to a certain extent for those individuals that are not qualified for Medicaid. Implementation of the Family Planning Waiver will address this problem using the following assumptions:

Case management services will be available to assist eligible women in securing transportation through local communities. Although demonstration eligibles will not have Non Emergency Transportation (NET) benefits available through the demonstration, the State has transportation Coordinators located throughout the

State. A component of their job responsibility is identification of resources within the local community that are available to low-income residents. This information will be available to the case managers to assist in their pursuit of transportation. In essence, the benefits of Medicaid's NET Program will indirectly assist demonstration eligibles.

Additionally, Case Managers will be located throughout the state, which will strengthen the ties to the local community as well as the available resources.

The formalized quality assurance program will include surveys to determine waiting times as well as number ofproviders available. This information will be invaluable to the state in determining areas in need of additional providers. Outreach efforts can be targeted to those areas that are most in need.

Information added after conference call:
The number of enrolled providers is not expected to increase significantly in total number, but will increase as a source of care for women without a payment source for family planning. For example, Depo Provera is a popular contraceptive method, but is expensive. Physicians who are willing to provide this care through Medicaid most likely will not be willing to provide it to a women without insurance. These same providers, however, are anticipated to serve the demonstration eligibles, as a source of payment will become available. The same is expected for other more expensive methods such as tubal ligations.

BUDGET NEUTRALITY
(1) Please revise the cost projections of this waiver to reflect only the cost for the first year of the child's life.

The income threshold for poverty level children aged 1-4 years in Alabama is 133% of the FPL.

Our data indicates that the vast majority of infants who become eligible for Medicaid under SOBRA (<133% FPL) remain enrolled in Medicaid for their first 5 years of life. As Alabama, through this demonstration waiver, averts births, then savings that accrue for these children who would have qualified and enrolled in Medicaid will extend beyond just their first year of life. To exclude expenditures for these children aged 1-4 from costs in the absence of a waiver results in an undercount of real savings.

(2) Please discuss and provide background for the assumed reductions of unintended births. Is the assumption drawn from published studies from other states or experience in Alabama? The assumptions result in a 20% reduction for the fifth year. Will a 20% reduction be achievable?

We were unable to locate reliable estimates for this that fit our particular circumstances. However, a study published by the Alan Guttmacher Institute in the September/October 1996 issue of Family Planning Perspectives indicates that in Alabama there is one unintended pregnancy averted for every 4.3 familyplanning clients seen. Our projections are that the waiver will result in approximately 31,961 new users of family planning services in the first year alone. Dividing this number by 4.3 gives an estimate of over 7,400 averted pregnancies. Yet, our conservative estimates are that there will only be 1,638 fewer births during the first two years of the waiver.

We note that we currently have a very low rate of participation in familyplanning for Medicaid covered women, and we believe this is because of the 60-day limit on coverage. Often these women come into the Title X clinics seeking tubal ligations after their Medicaid coverage has ceased. Unfortunately, very little Title X money is allocated for tubals, resulting in these women being put on a very long waiting list for the procedure. This waiver would make tubal ligations readily available to any future SOBRA women who lose eligibility, as well as to those who are already on the waiting list in Title X clinics. Since sterilizations are the most effective family planning "method," we could expect the number of averted births to be even higher than estimated.

Although we are expecting a 20% decrease in the pregnancy rate over 5 years, this could still be considered conservative, since this translates into a reduction of from 1.9 to 1.5 the overall state average pregnancy rate.

(3) What is the source for the 6.2% inflation rate factor, which was discussed on pg. 25 paragraph #3?

The yearly inflation rate factor of 6.02% is based on the average benefit expenditures per Medicaid eligible as derived from the HCFA-2082 reports. In FY'94 the average cost per eligible was $2112 and by FY'98 had increased to $2678. This is an increase of 26.8% over four years, with an annual growth rate of slightly over

6%.

CARE COORDINATION SERVICES

Direct services will be augmented with care coordination and tracking for "high risk" and "at risk" women to ensure compliance with the woman's chosen method. Please provide more detailed information explaining the operation of the care coordination and tracking component (page 13) of this proposal - including information on additional policy and reimbursement requirements which the State mentions will be developed (page10). Specifically:

a) How are the categories "high risk" and "at risk" being defined? The implementation of proposed expansion program with offer family planning services to an estimated 100,000 women annually (page 6). Of this, what proportion are estimated to be at "high risk" or "at risk?"

Both "high risk" and "at risk" describes those women most at risk for an unintended pregnancy. Women can be at risk for an unintendedpregnancy for a variety of reasons. Please refer to p. 15 of the proposal for a listing of some of the factors that would define a woman as being "high risk" or "at risk".

We are estimating that 15% (please refer to p. 26 of the proposal) of women assessed for risk will be "high risk" or "at risk" and require follow-up by the care coordinator.

b) Page 12 indicates that Medicaid would reimburse for the care coordination services on a per hour basis. What estimates are available on the size of the potential "care coordination" population, the cost per hour of the service, and the average number of hours that may be required per client? Page 12 seems to indicate that care coordination will be available to all women, yet other parts of the application indicate that this service is limited to "high risk" clients. Page 12 seems to indicate that care coordination will be available to all women, yet other parts of the application indicate that this service is limited to "high risk" clients. Please clarify.

It is estimated that approximately 111,000 women will become eligible for familyplanning services under this waiver. An estimated 15% of these women (see p. 26 of proposal) will be assessed by the care coordinator to be "high risk" and will require follow-up by the care coordinator. The statement on p. 12 regarding services availability to all women who are eligible under the waiver refers to the availability of assessment for care

coordination.

The care coordinator will interview all women who are eligible for familyplanning services under this waiver and a risk assessment will be done at that first interview. The care coordinator will then follow women who are determined to be "high risk" for unintendedpregnancy. The care coordinator will not follow women who determined to be "low risk". It is projected that women assessed as "High risk" will receive an average of four hours of care coordination annually (see p. 26 of proposal). All women will be eligible for and will receive the initial assessment. It is estimated that the initial assessment will average 15 minutes per client (see p. 26 of proposal). Care coordination cost is projected to be $34.00 an hour (see p. 26 of proposal). Please refer to the Budget submitted with this proposal for further clarification on cost.

(c) Page 10 states the Alabama Department of Public Health will have responsibility for providing care coordination services to clients, as requested by the provider (public or private). What guidance or training will be available to providers on when/whether care coordination may be needed for a client? Page 15 indicates that the State will assess the risk status of all waiver clients by reviewing the patient's medical record and/or administration of a high risk-screening tool developed by the State. Does such a protocol already exist? If not, who will develop and test it? Would such a tool be ready at the start of this demonstration program?

Alabama Department of Public Health care coordinators will work closely with local family planning providers and will inform them of the family planning services available through this waiver (see pp. 14, 16, & 17 of proposal). The care coordinators will have the responsibility of informing the family planning providers of the care coordination services that are a part of this waiver. Screening for risk will be the responsibility of the care coordinator (see p. 15 of the proposal).
Protocol for this program, including a family planning risk assessment tool does not currently exist. The Alabama Medicaid Agency and the Alabama Department of Public Health will jointly develop the protocol and the assessment tool upon approval of the waiver. Both the protocol and assessment tool will be ready at the start of this expansion program.

Information added after conference call

Community providers will receive information about the program through Medicaid provider notices. Additional information and follow-up will be provided through the Medicaid Managed Care Newsletter. Individual visits to as many providers as possible will be made to explain the program and encourage participation. Periodic contacts will be made to ensure continued understanding. There will be no formal schedule of visits.

(d) Please explain the process for women "enrolling" in the care coordination program (page 13).

Please refer to Attachments 5 and 6 "Care Coordination Flow Charts" for this process. Patients presenting for family planning services either at the Health Department or at private offices will be assessed for risk for unintendedpregnancy by a FPCC. Patients seen at the Health Department will be referred to the FPCC after their clinical exam. Patients seen in private offices will be given information about care coordination, to include the care coordinator's name, location and a telephone number. The FPCC will work closely with the clinical staff at both the Health Department and the private physician's office to ensure that timely referrals are made for care coordination.

(e) How many care coordinators does the state estimate will be employed and trained (page 14-15)?

It is estimated that approximately 30 care coordinators will be required statewide to provide services under this waiver. Existing employees of ADPH will be utilized to provide this service. Public Health nurses and social workers are presently located in all 67 counties in Alabama. The shift from direct service delivery to community-based services that we are seeing in Alabama will allow for nurses already employed by Public Health to move into care coordination, in addition to the Public Health social workers who are alreadyproviding care coordination in other programs at the county level.

(f) Does a curriculum on family planning care coordination already exist, or does one need to be developed for approval by the Medicaid agency (page 15)?

A curriculum for care coordination has been developed by the Alabama Department of Public Health and approved by Alabama Medicaid Agency. This curriculum will be modified to specifically cover family planning and will be submitted for review upon

approval of the waiver.

Information added after conference call:
A draft curriculum is attached for your review as Attachment 1.

(2) Care coordination, which appears to be similar to case management, would appear to be a very important component in ensuring that beneficiaries properly benefit from family planning services. The State should explain why this is an optional service, rather than a routine service provided to all beneficiaries.

Care coordination is an important component in this waiver. The focus of this proposal to provide care coordination only to women determined to be at high risk for an unintended pregnancy was influenced by funding and staffing limitations. While all women may benefit from care coordination services, staffing and funding limitations make identification of those women most at risk for unintended pregnancies a critical component of the waiver. Following only those women who are determined by the Care Coordinator to be at "high risk" will allow the care coordinator to focus on those women who are most in need of intensive follow-up.

(3) What is the rationale for "care coordination"? How was the need for this component assessed? Will high-risk women only receive 4 hours of service no matter how long they are enrolled? Is care coordination new for the purposes of this waiver or has it been used in other contexts with family planning? If so, how was it assessed and what was the effect of it?

Please refer to the PRAMS survey on page 9 of the proposal in which 95% of the respondents to the county needs assessment survey listed "families don't know the importance of preventive and primary care" as a barrier to the use of family planning services. Also, note on p. 9 that 40% of those surveyed said they were using a method of birth control when they became pregnant. Many were using birth control pills but may not have understood how to use them properly. In addition, half of the respondents listed lack of information on available resources as a barrier to the use of family planning services. Care coordinators will use the nationally recognized PT+3 program to address these issues (see p. 7 of the proposal). Care coordinators will focus on the tasks listed on p. 16 of the proposal.

Intervention by the care coordinator will allow women who are determined to be at "high risk" for unintended pregnancy to have birth control methods explained in an easily understood manner, give the women an opportunity to ask questions, be encouraged to seek assistance for addictions and other psycho-social problems that may be negatively impacting their birth control efforts, be reminded of medical appointments, etc. Please refer to the Budget regarding the four hours of annual care coordination.

Care coordination is new to family planning in Alabama. However, the Alabama Department of Public Health has provided case management and care coordination under several other programs, i.e., maternity, HIV/AIDS, and children with disabling health conditions. Alabama will soon be providing case management to those Medicaid-eligible patients who are determined by their physicians to be medically at-risk because of barriers to receiving health care and/or multiple psycho-social problems that impact the health care they are receiving. Care coordination and case management has been instrumental in Alabama in ensuring that pregnant women receive early and continuous prenatal care; in providing health care, education and support to HIV patients and children with disabling health conditions.

Information added after conference call
Patients considered at very high risk for unintended pregnancy will receive individualized case management averaging 4 hours per year. This estimate of use will allow frequent contact with these patients. Remember that women who choose sterilizations and women using methods such as Depo will often move out of the more intensive group.

(4) Please describe more on how the care coordination will work with private providers. How will the FPCC interact with the family planning provider (e.g. how will referrals to the FPCC be made)? If a woman applies for family planning services with an out stationed eligibility worker, will she be visited by an FPCC or will she only receive the brochure? If an FPCC determines that a woman is "low-risk," can the woman still request care coordination services?

This program will be actively marketed to providers by the care coordinators (please refer to p. 14 of the proposal). The care coordinator will establish a relationship with the family planning providers and will educate the provider and staff as to how referrals **can** *be made from the providers' offices to the* ***FPCC.***

Please refer to pp.16 & 17 of the proposal and Attachments A and B, Care Coordination Flow Charts, for additional information on interaction between the provider and the care coordinator. As stated on pp. 16 & 17 of the proposal, there will be regular interaction between the care coordinator and the providers.

Outstationed workers will be responsible only for providing eligible women with brochures with the telephone number of the FPCC at the time of application. Alabama Medicaid will provide the county FPCCs with a monthly list of eligibles, including names, addresses, and phone numbers (see p. 17 of proposal). The FPCC will use this list as an outreach tool to encourage eligible women to make their initial family planning appointment. Women who are determined to be "low risk" by the FPCC but who request care coordination services for a problem not identified during the initial assessment process can be reassessed and receive care coordination follow-up.

Set 2 Questions

1) Please provide a discussion of the proposed activities of the Family Planning Care Coordinators.

Refer to the above question number 4. In summary, routine care coordination activities include but are not limited to:

a. Reviewing the list of new eligibles
b. Contacting new program eligibles
c. Performing risk assessments
d. Performing psycho-social assessments and developing care plans
e. Following-up on high risk patients
f. Contacting family planning providers to explain and offer care coordination services
g. Accepting referrals for case management services
h. Following-up on referrals
i. Documenting care coordination activities

(2) Please provide HCFA with the curriculum for the coordinators.

Draft curriculum is attached to this document as Attachment 1

(3) Please explain why only **15%** of the eligible women will be entitled for case management. Given the fact that these women were previously uninsured and were likely underserved, we would expect the number requiring this service to be much higher.

Please refer to answer to question ***(f)(2).***

(4) Please explain how Alabama derived the estimate for the proportion of women as "high risk."
Refer to number 3 above

(5) Please provide the care coordination risk assessment tool for the family planning program.
Draft tool is attached as Attachment **2**

(6) Please provide evidence which demonstrates that case management significantly improves the well being of the target population. Please present evidence from the HIV and Prenatal Case Management Programs currently operating in Alabama.
There have been no formal evaluations or outcome studies of the **TCM** *Program. Success of the program is evidenced anecdotally and appears to be a needed service. Providers report better compliance rates for case managed individuals as well as support systems for persons that are compliant. Specifically, HIV beneficiaries are in need of a solid support system and case management meets this need. Helping them sort through the myriad of health related issues is invaluable. This Maternity Waiver program has used a case management component for years and we are confident that this is one* ***of*** *the reasons that this program is successful. Prenatal visits rose once this component of care was added through the waiver.*

(7) Please describe how providers will be trained to access the program.
Providers will receive information directly from the Alabama Medicaid in the form of a Provider Notice that will advise of the program. Information will include services covered, population to be served, and general information on how to refer for care coordination. Additionally, providers will be contacted by a care coordinator within the local community to explain the services available to the provider.

(8) Please explain the interface between the care coordinators and the providers.
Care coordinators will reside within the local community and frequently work with these providers in other programs. Providers will be advised of how to contact care coordinators and ***of*** *services that can be provided. Care coordinators will leave information about the program with the provider which*

includes name and telephone number of the care coordinator. Interface will generally be either by phone, by written referral or follow-up reporting done by the care coordinator.

ELIGIBILITY

(1) How will women be notified at the termination of their existing Medicaid eligibility that they will be eligible for the waiver?

Notices similar to the ones that were in the Bay Health Plan demonstration waiver will notify women. See Attachment **3**

(2) Will women applying for Medicaid for their children be made aware of their own potential eligibility for the waiver? If so, how?

Women applying for Medicaid will be notified verbally of their potential eligibility for family planning services. The application form will be modified to reflect that it is an application for family planning services for women age 19-44. Informational materials for the ***SOBRA*** *program will also be revised to reflect the requirements for eligibility for family planning services.*

(3) Would men be included in this family planning demonstration?

No

(4) When a woman applies for family planning services, will there be a significant delay between application and receiving the services? For example, if a woman applies early in the month and the Medicaid agency does not send the monthly list of eligibles to the FPCC until early the next month, will the woman be prevented from receiving services until she has the initial contact from the FPCC?

When a woman applies for Medicaid services, there is a 45-day time frame for the worker to process the application. The applications for only family planning services will require a much shorter time frame for processing since income verification will not be required. We refer to this as an "expedited" application process. Once the woman is approved eligible for family planning services, she is notified through a written award notice and may begin to receive services immediately through the family planning provider of her choice. Eligibility will be approved back to the beginning of the month ***of*** *application.* ***Thus*** *we will not provide the normal three months of retroactive eligibility for women approved through*

this family planning waiver. The woman's receipt of services is not contingent upon contact with the FPCC.

ENROLLMENT

(1) Please explain the justification for certifying women for the term of the demonstration? What would be the additional cost/burden if the State recertified women each year? Does the State plan to evaluate whether this type of certification is cost-effective? For example, how many women remained below the income eligibility threshold? How many women would *not* have followed through with the recertification process resulting in a loss of coverage?

Certification of women for the term of the demonstration was an adjustment on our part to overcome the administrative burden of recertification of these women. The proposed design of the enrollment plan was originally adopted from Bay Health Plan and would have required 2-year intervals with recertification. We are currently unable to make systematic adjustments that would allow for a separate recertification date for these women that would be different from the current family review date. Without the separate review date there is no way to maintain a system that would identify a separate time to redetermine eligibility for these women.

The cost for completing another annual review on approximately 100,000 new eligibles would be approximately $750,000 annually for the time spent by the eligibility workers to complete the reviews. If at least 3 reviews were completed during the waiver period, the cost would be $2,250,000. We would also incur an additional cost of approximately $500,000 for the systems changes necessary to add a new review date field to the system.

This condition

In summary, although yearly re-certifications are not required, the majority of women who participate will have children who qualify for the SOBRA program, which requires annual re-certification. If it is determined during the re-certification that income exceeds the demonstration guidelines, the woman will be de-certified from the demonstration.

(2) Please provide the new application developed for the proposed Family Planning Program.
Application attached to this document as attachment 4

(3) Please explain the justification for certifying women for the term of the demonstration. How frequently does Alabama redetermine Medicaid eligibility?
The state has reviewed the certification process in detail and has determined that the most efficient and cost effective way to determine eligibility is to add the enrollees for the term of the waiver. However, that does not mean that they are never de-certified. If the woman has minor children certified for Medicaid an annual re-certification is necessary. If it is determined that the income exceeds standards, she will be removed from the program. Beneficiaries will be asked to report a change in income. When the income is reported, the woman will be de-certified from the program.
What is the income verification mechanism in Alabama?
See below
Will Alabama verify eligibility of target population?
See below
What measures will Alabama take to verify income?

We intend to provide verification of income through the federally mandated Income Eligibility Verification System (IEVS) which is already in place in the state. This system verifies each recipient's earnings through matching with other state and federal databases to verify earned and unearned income from sources such as IRS, unemployment, food stamps, TANF, the Alabama Department of Industrial Relations, and the Social Security Administration. Information on each SSN where there is a matching record is reported to the agency, and we investigate the reported information to determine if it is consistent with what the recipient reported to the agency. We recoup misspent funds if the certification was erroneous due to fraud. The state also utilizes the State Verification Exchange System (SVES), which matches with

the Social Security Administration in a similar fashion to verify dates of birth, SSN's and income provided by the Social Security Administration. Not requiring the recipients to provide documentation will allow a much more expedient application process and allow the recipients to receive services sooner. We have also seen more of an encouragement by HCFA in recent years to relax our verification requirements in the Medicaid program. This has been especially true since the inception of the title XXI CHIP program, which has no requirement for verification of any eligibility requirements with the exception of alienage for non-citizens. With the joint application process for CHIP (ALL KIDS in Alabama) and Medicaid, We are trying to align the Medicaid rules as closely as we can with the ALL KIDS rules. Since the only verification requirement for Medicaid are verification of SSN, alienage, and IEVS requirements, we feel very comfortable allowing self-declaration of income for the new family planning recipients. Most of the women in the familyplanning waiver will have children who are already enrolled in the SOBRA program, and whose income has already been verified. Currently families are required to provide documentation of their income at application, and at the annual review. Therefore the majority of the women in the demonstration project will have already provided documentation of their income.

EVALUATION

(1) What are your plans for developing and implementing the evaluation and will the contractor UAB provide assistance in designing, implementing and conducting the evaluation.

The final evaluation component of the waiver will be developed with the assistance of the University of Alabama. UAB has already played a pivotal role in the development of the project and will continue in this capacity. The initial design included in the waiver was developed in conjunction with UAB and additional design activities will be completed once the State feels comfortable that the project will be approved. The expertise and guidance that will be provided within the University of Alabama will be invaluable to the project. UAB has worked with the Department of Public Health as well as Medicaid on other initiatives and has as performed evaluations of other health care initiatives for other populations and health care initiatives.

UAB will assist the state in data collection and preliminary data

analysis as well as assist in development of the bid for the independent assessment that is required for demonstrations. It is anticipated that much of the work that is done through the university can be assessed and validated through the independent reviewer. It is essential that appropriate data be collected prior to implementation to ensure that the information that will be needed for the review is collected.

Information added after the conference call

It is the state's understanding from information provided during the 8-23-99 conference call that HCFA will require the evaluation plan within 60 days of the approval of the waiver. It is also our understandinq from the call that the evaluation component of the demonstration can be met through the UAB activities as long as the plan and methodology is approved by HCFA within 60 days of the demonstration approval.

(2) What will be the critical job requirements in the scope of work?

At this point the critical job requirements for the evaluation process have not been finalized. This will be undertaken once there is an indication from HCFA that the waiver will be approved. However, it is anticipated that the critical job requirements will include:

1. *Ability to collect and analyze large data sets*
2. *Ability to evaluate public awareness of the availability of family planning services*
3. *Ability to evaluate the educational component of the waiver*
4. *Understanding of the low income population*
5. *Understanding of the Medicaid and Public Health care delivery system*
6. *Ability to "test the message"*

It is anticipated that the scope of work will include:

1. *Analysis of pregnancy rates*
2. *Analysis of access to care, including identification of areas that care needs are not adequately met.*
3. *Analysis of program utilization*
4. *Analysis of the outreach and care coordination components of the program*
5. *Projection of savings through averted pregnancies*
6. *Assist the state in determining benchmarks for evaluation purposes*

7. *Identification of strengths/weaknesses of the program and recommendations for improvement.*
8. *Evaluation of the effectiveness of the outreach component of the demonstration.*
9. *Tracking provider participation rates*

Please note that these items are not final and will most likely evolve as the details of the program begin to take final shape.

(3) For each hypothesis, please identify the data needed to perform the test and the source of the data?

Hypothesis 1	*Medicaid claims data*	*Medicaid*
	Vital Statistics records	*Dept. of Public Health*
	Birth 'Certificates	
	Population demographics	*Dept. of Public Health*
Hypothesis 2	*Medicaid claims data*	*Medicaid*
Hypothesis 3	*Medicaid claims data*	*Medicaid*
Hypothesis 4	*Survey information*	*Survey results*
Hypothesis 5	*Birth Certificates*	*Dept. of Public Health*
	Medicaid claims data	
Hypothesis 6	*Care Coordination Records*	*Dept. of Public Health*

(4) How will the evaluation components differ for high-risk women with care coordination services and women without the additional services?

It is not anticipated that a separate evaluation will be conducted for high-risk women.

Information added after the conference call

A component of the evaluation will be targeted to women that have been identified as high risk through the risk assessment.

(5) How was PT+3 originally funded? The "Final Report" indicates the problems that occurred in the evaluation process and states that "no formal evaluation has been done." Considering how important PT+3 is to the care coordination model, does the State plan to initiate a formal evaluation?

PT + 3 was originally funded by a grant from the Pharmacia & Upjohn Company. It was a collaborative effort between Saundra Ivey, RN, MSN, MA, CRNP, the Auburn University at Montgomery (AUM) School of Nursing, the Alabama Department of Public Health (ADPH) and Medicaid. Ms. Ivey has submitted an evaluation plan to test

the hypothesis that "a significantly greater proportion of patients exposed to a structured patient communication/education method, PT + 3, will successfully delay pregnancy for one year than will patients exposed to non-structured, topic driven patient education." Data collection will begin in December 1999. The final report will be submitted to Medicaid by April 28, 2001.

Information added after conference call

PT+3 is an appropriate tool for use in this demonstration. PT+3 has been presented at national family planning seminars, received the 1998 Innovations in Government award, has been supplied to managed care organizations in several states, and has been presented to residency programs at one of the state's medical schools at their reqyest. Such acceptance by organizations and training programs serves as evidence that PT+3 is a well conceived and presented method of education with a high potential for success.

Set 2 Questions

(1) Please provide a proposal for completing an evaluation plan for this waiver. Who will develop the evaluation and what are the qualifications of the proposed evaluation team personnel? The hypotheses and objectives for the evaluation plan should be limited to those that can be reasonably expected to be impacted by the demonstration. Since men and teenagers (except 19 year olds) will not be eligible for the proposed demonstration, objectives for them should not be included in the evaluation design.

Evaluation will center on the objectives outlined in the waiver request. To summarize, the objectives are as follows:

1. To reduce the rate of unintendedpregnancies
2. To improve access to family planning services to women in the state. (Please note that reference to teens and men will be deleted.
3. Reduce Medicaid costs for unintended deliveries
4. To utilize effective outreach programs
5. Utilize care coordination to assist women in consistently using a family planning method
6. To ensure that education concerning family planning methods is communicated in a meaningful and understandable way.

The UAB Graduate School of Public Health will be the designated entity to perform the evaluation. The team from UAB will include a physician, a Ph.D. prepared analyst, graduate

students receiving advanced degrees in public health, other UAB Departments as needed as well as other staff members that have not been named as of this date. The full staff will be defined and provided to HCFA along with the final evaluation plan upon approval.
A draft of the preliminary evaluation is included. See Attachment 5 Please note that this is not final at this time.

(2) Please explain the data collection strategy to evaluate the demonstration.
Please see answer to the question 1 above and the UAB draft evaluation plan

(3) Please develbp a plan to evaluate averted births for high-risk women receiving case management and for women who did not receive case management.
Please see answer to the question 1 above and the UAB draft evaluation plan

(4) Please provide an update on the evaluation plan developed by Saundra Ivey, RN, MSN.

According to Saundra Ivey, work on the evaluation process for PT + 3 has begun.
The data collection forms are in the final draft stages. Contract arrangements with the rural site are in process. Staff at this site have reviewed the data collection forms for ease of completion and understanding. She plans to meet with the clinical staff at the urban site to address concerns and questions and expects to receive their agreement to participate. Data will be collected on the first 100 patients without staff training in the modified PT + 3 protocol. The staff will then be trained. Data will then be collected on the "intervention" group. This method will prevent cross contamination. Data collection from the control group will begin in late October. Training in the protocol will occur in December or early January. Data collection on the intervention group will begin immediately following the training. Work is also being done to program the computers for data transmission. This should be complete by October 1.

OUTREACH

(1) What is the plan for developing and implementing the outreach plan?

The outreach plan for this waiver will be developed cooperatively between the Alabama Department of Public Health and Medicaid.

ADPH will be responsible for:

a) Establishing measurable goals and outreach strategies for the statewide waiver program that are consistent with the overall goals of the waiver and contain minimum required elements as specified by Medicaid;

b) Communication of goals and strategies to local care coordinators who in turn will develop outreach plans for each public health area;

c) Providing research assistance and other support (e.g. data) to local care coordinators for use in outreach plan development;

d) Coordination and compilation of local plans into a statewide outreach plan, plus development of statewide initiatives to be conducted at the state level, for submission to Medicaid

e) Evaluation of the outreach plan on a periodic basic (at least annually).

Medicaid will be responsible for approving the outreach plan and all related materials prior to implementation.

2) Will outreach be targeted to all women and not just eligible women? What is the forum for outreach at the local level?

Outreach activities under this waiver will be targeted generally to all women who are eligible for services under the waiver. Within the larger group, subgroups will be identified for specific, localized outreach efforts. For example, there will be outreach efforts targeted to women in the third trimester of pregnancy and/or in the post-partum period.

Each public health area will have the opportunity to develop local outreach efforts that address unique local factors or demographics such as a Native American or Hispanic population or a high

incidence of second or higher births spaced less than two years apart.

The forum for outreach is expected to be diverse and reflect the needs of the community. As the presence in the local community, ADPH will conduct an assessment of the needs in the community and will facilitate the identification of local needs by developing community partnerships with relevant local groups, including advocacy groups. By doing this, the outreach effort will respond to the specific needs of the community. At the same time, the overall support available at the state level will support and enhance local efforts.

Set 2 Question
(1) Although the public health service area will be developing local outreach strategies which significantly meet the needs of local community residents, please provide an initial outreach plan with possible time frames and activities to be implemented.

Initial Plan - Within first 30 days of waiver implementation.

1) Medicaid will notify postpartum SOBRA clients and women who have SOBRA eligible children through automatic systems-generated notice about the newprogram and that they are eligible for coverage.

2) Clients not-Medicaid eligible who present for family planning services at clinics will be advised of the program and referred to local outstationed Medicaid eligibility workers to apply for program eligibility.

3) The ADPH toll-free telephone line will be available for callers throughout the state.

4) 4) Training will be provided family planning providers on the PT+3 counseling/education methodology.

5) One-on-one client outreach will be provided through the PT+3 education and counseling method.

6) Brochures will be developed to advertise the program to both providers and clients.

7) Area level ADPH staff will be identified as outreach contacts to participate in local outreach needs assessment and plan development.

8) Local outreach regarding care coordination availability will be provided by ADPH family planning care coordinators to private providers of family planning services.

9) Information on the new family planning waiver program will be advertised on the Medicaid and ADPH web site.

Medicaid and Public Health will meet to establish strategy and begin development of an overall outreach plan to be included in the 'operational protocol manual.

PROGRAM ADMINISTRATION

(1) What is the interaction between this proposed waiver, Title X and Medicaid?

As stated in the Executive Summary, page 4, and in Project Administration, Pages 9-11, the demonstration is a joint effort between the Department of Public Health and the Medicaid Agency. Both agencies recognize the impact that unintended pregnancies have on women and children as well as the state in general. By working in tandem it is anticipated that the project will have a much greater impact and greatly enhance the potential for success. This is not a Medicaid problem or a Health Department; it is an Alabama problem.

The agencies have worked together from the beginning of the project design and have an excellent relationship. Although the Medicaid Agency will administer the waiver, we will be partners with our sister agency who has expertise in case management, provision of family planning services and working with low-income populations. Medicaid and Public Health do not serve under an umbrella agency as is true in many other states. As such, there has been a historical relationship with the Department of Public Health on numerous health care initiatives. Monthly meetings are held between the agencies, as has been the practice for many years. This meetings focus on joint initiatives, problem solving and is a forum for open discussions that impact beneficiaries, Medicaid and Public Health.

Implementation of the demonstration will be treated in the same manner as other initiatives. Our goal is to work together to enhance the health care infrastructure available within the state and to enhance availability of needed services.

(2) Does Alabama plan to address the findings of the Annual Report cited on p. 8, in particular the finding on data capacity? How are family planning services underutilized in Alabama and how was the "needs met" rate determined?

Data capacity - This issue related mostly to the ability to obtain and analyze family planning data beyond what is routinely captured through the ADPH's current patient encounter data management system, i.e., population based survey data, data from other reporting systems (Medicaid maternity patients receiving family planning at postpartum when patients don't complete care through health department system), tracking/follow-up, etc. A staff person within the Bureau of FHS whose primary job is data management was appointed in 1997; however, due to this person transferring and due to budget cuts over the previous year this position has not been refilled. Also, the Bureau's MCH epidemiologist assumed grant-writing responsibilities in addition to epidemiological responsibilities.

Plans

(1) The MCH epidemiologist will continue efforts to identify a way to estimate the proportion of established ADPH maternity patients who return for family planning services; and state FP Program staff will network with the State Medicaid Agency to encourage them to ascertain the proportion of maternity patients returning for family planning services.

(2) ADPH's new computer system, the Public Health of Alabama County Operations Network (PHALCON), is expected to be fully implemented by December 1999. This system will have many enhancements compared to the previous system, which should help staff to better follow family planning patients, which may help prevent unintended pregnancies among these patients. The system will enable the operator to see the enrollment data in each service area, search for the most recent family planning encounters as well as see the history of all family planning encounters. Moreover, the patient referral information will be more specific to provider and condition, thus helping with Pap smear follow-up.

(3) FP Program staff will complete analysis of data from the

population-based family planning survey and apply results in implementation of outreach activities where applicable.

Underutilization of family planning - "needs met" - The **Alabama Family** *Planning Program offers services to all individuals who want to participate in the program; however, services are targeted to individuals who are below 150 percent of the federal poverty level and all teenagers (age* **<20)**. *The number in the in need population thus includes the number of women below 150 percent of poverty and all teenagers. This number* **(197,060)** *is obtained from The Alan Guttmacher Institute, Readings on Family Planning Needs and Services, page* **76.** *During* **FY 1997-98, 89,260** *family planning patients were served in ADPH clinics. Of this number* **83,102** *were below* **150** *percent of poverty and/or teenagers, resulting in an in need met* **of 42.2** *percent.*

(3) The application details the responsibilities of the Department of Public Health, but not the Medicaid Agency (p. 10). What will be the responsibilities of the Medicaid Agency?

Medicaid will function as the administrative agency for the demonstration. **As** *such, duties and responsibilities include, but are not limited to:*

Eligibility certification - This function will be incorporated through the **SOBRA** *Program*

Quality Assurance - This function will be housed in the Medicaid Quality Assurance Division. The waiver request, pages **20-21,** *outlines goals and protocols that will be utilized for the demonstration.*

Waiver management - *This function will be housed in the Managed Care Division. However, there will be close coordination with the Medical Services Division, which has responsibility for the Medicaid Family Planning Program. Duties include, but are not limited* **to,** *data retrieval, monitoring service provision, monitoring services provided by the Health Department, waiver application, waiver renewal, quarterly conference calls, the Operational Protocol Manual, HCFA correspondence, coordination of waiver activities, and working with the Project evaluator.*

Approval **of** *Marketing Materials - This will be housed in the Medicaid Beneficiary* **Support** *Division. This division will* **also**

coordinate recipient survey activities.

Medical Service Delivery - The Medical Services Division will monitor provision of medical services to ensure that program requirements are followed.

(4) Please discuss Alabama's experience in developing the Family Planning program in Mobile and its impact on Alabama's new statewide initiative.

Alabama had an 1115 Research and Demonstration Waiver that was operational in Mobile County. A component of this waiver was expanded eligibility for SOBRA eligible women who deliver during the demonstration. Although the programs are structured differently, the overall goals are the same. Because of this demonstration Medicaid will be able to utilize functionality of claims processing system to enroll and reimburse for services without significant system changes. In the Family Planning demonstration, claims will be paid fee for service whereas in BAY Health Plan the service was capitated.

We have learned some valuable lessons about this population in the BAY demonstration that will be helpful in the new initiative. One lesson is the mobility of the population served, difficulty of the educational process and the need for family planning outreach. This is generally a younger population and services must be readily available if the demonstration is to be successful.

Set 2 Questions

(1) What is the interaction between this proposed waiver, Title X and Medicaid?

Title X is one model of delivery of family planning. This demonstration will allow eligible patients to receive their care from traditional Health Department clinics and from newly available private providers. Use of private providers will free limited Health Department staff to be able to serve patients now on waiting lists waiting for services. Limited funding has also made more expensive services that some patients might prefer such as tubal ligations unavailable or available only after long waits.

(2) Please discuss Alabama's development of a data system to track services provided to this target population and to evaluate the goals and objectives of the waiver.

Additional information on PHALCON is documented in the Set 1 questions. This system will be utilized by the care coordinator to enter care coordination tracking information. This will be operational in Dec 1999. The Medicaid claims system is operational to track benefits provided through claims. Information from the claims system will be used to evaluate many of the program hypotheses.
These are the two primary data systems that will be used, although information will secured from other areas such as birth statistic records at the Health Department.

(3) Please discuss Alabama's experience with the Family Planning Program implemented in Mobile. Is care coordination part of this program? What valuable lessons about the population in the Bay Health Plan have been learned which will improve the implementation of this statewide demonstration?
***As** discussed above, this is a mobile population and the need for consistent follow-up **is** needed, including expertise of experienced care coordinators. Tracking and follow-up needs to be documented and easily retrievable to provide needed information for case management.*

PROVIDER NETWORK

(1) Women in the expansion program would be able to access family planning services directly through any qualified provider. Please describe any training efforts that are being considered to ensure that all providers are competent in the delivery of family planning services.

*The current Family Planning manual, which will be an appendix in the 2000 Provider Billing manual, states that providers "must utilize the PT + **3** teaching method, after the provider has received training." Please refer to the answer to question **2** regarding training. The staff **of** the Outreach & Education unit also conducts inservice education about familyplanning upon a provider's request. The staff is also available to answer questions by telephone or e-mail.*

(2) Describe the process for training current and additional providers on the care coordination component. Page 4 states that the PT+3 training and educational program about family planning has been offered statewide. Yet page 10 seems to indicate that "adjunct training" in the use of the PT+3 protocol to the *Title X family planning department* providers will be the responsibility of

the Alabama Department of Public Health. Have private providers been trained in PT+3? Are there plans to do so in the future? And, who will be responsible for conducting training of private providers? Please provide more information about the numbers of providers already trained in PT+3, and any information about how the PT+3 program is tracked. Please provide further detail on the State's plan to recruit additional providers (page 7). Please explain how the state will monitor the geographic distribution of participating family planning providers (page 13).

A total of 465 private providers were trained in the PT + 3 method from 9/97-5/98. PT + 3 is currently being refined by Saundra Ivey, to make it more "user-friendly" and time efficient. The goal is to provide training to all family planning providers, including those who have already been trained. Ms. Ivey will train six Medicaid staff members from the Outreach and Education units. These staff members will be responsible for instructing the private providers in six area wide sessions throughout November 1999. Additional training sessions will be scheduled as needed. Laurie Stout with ADPH is the contact person for questions concerning the training of Title X family planning department providers.

The names of providers who have received training are maintained on a computer file. The Outreach & Education unit is publicizing PT + 3 and family planning during provider visits and conferences. Moreover, information will be available through the EDS Bulletin, (the newsletter for Medicaid providers), on Medicaid's web site and possibly other forums, such as the Medical Association of the State of Alabama's (MASA) newsletter and the Alabama Academy of Family Physicians' newsletter.

Upon completion of the training sessions in November, Medicaid staff will review the geographic distribution of providers, i.e., how many attended in each area, to determine areas of need.

TEEN AGED BENEFICIARIES

(1) Please clarify how the expansion will affect teens. On page 3, the State indicates that the waiver program would limit the eligible population to women aged 19-44 with incomes at or below 133% of the FPL. Yet on page 11, the estimate of the eligible clients seems to include teens in the CHIP, phase one program, some of the proposed outreach activities are directed at teens, and some of the evaluation questions include teen measures. Page 7 states that teen mothers (age 10-19) have high birth rates in Alabama, but family planning services are already available

through the Medicaid and CHIP programs. Respond specifically to:

(a) Are these services readily available on a confidential basis to teens?
Federal law and regulations prohibit requiring parental consent for minors receiving Medicaid family planning services. We believe that the policy described on page 5 of Chapter 3 of the Family Planning Provider Manual may violate this requirement. It implies that parental consent is the rule, and that a minor who refuses to have parental involvement may be denied services unless the physician determines that "withholding contraceptive information and services will be detrimental to the physical and mental well-being of the minor."

The Family Planning appendix to the 2000 Provider Billing Manual no longer contains the aforementioned citation. The section regarding "Consent of a minor" states, "Any minor who is 14 years of age or older, or has graduated from high school, or is married, or is divorced, or is pregnant, may give effective consent to any legally authorized medical, dental, health, or mental health services for himself or herself. The consent of another person is not necessary."

Information added after conference call
This demonstration will provide services to patients age 19 to 44 only. Patients less than 19 will not be enrolled.

(b) Explain how family planning services would be accessed under the ALL-kids program and its relationship or linkages with the proposed expansion waiver.

Teens up to the age of 19 are covered for Family Planning Services under both CHIP Phase I (Medicaid) and ALL Kids. Since this age group is already eligible for familyplanning services, teens are not part of the expansion of Family Planning Services described in this proposal. There is no formal linkage between the Allkids and the demonstration.

(c) Would adolescents not be considered "high risk" or "at risk" vulnerable populations who would be in need of the care coordination and tracking services proposed in the pending waiver? Is care coordination offered to the adolescent population in other Alabama's programs? Why won't teens be able to enroll in the waiver if they are not participating in other programs they are eligible for (p. 12)?

Adolescents are considered "high risk" or "at risk". However, this population has access to services through other Medicaid programs or through the CHIP program, Allkids. Teens are enrolled in Medicaid's Patient 1st program and have a Primary Medical Provider (PMP). Additionally, they can seek family planning without the need for a referral from their PMP. The group of women to be served through this demonstration are not categorically eligible for Medicaid and therefore it was determined that there were unmet needs that should be addressed. This waiver is designed to meet those needs.

QUALITY ASSURANCE

(1) Please describe in detail how the quality of the family planning services will be assured.

The waiver application, pages 20-21, outlines processes that are to be in place for the demonstration. It should be noted that this demonstration will utilize a fee for service reimbursement methodology that is already in place for the general Medicaid program. Procedures that are currently in place will not be discontinued, but will be enhanced by the demonstration. Services will be subject to S/UR review as well as routine program monitoring through the Acute Care Division.

Many Managed Care principles will be applied to the program that look at a broader care issues including accessibility of care in terms of wait times, etc., availability of providers and a structured complaint and grievance process. Additionally, structured review of encounter content and case management will compliment the overall process. The Agency anticipates an additional staff person will be required to commit to the program, as quality is a priority.

(2) Please explain how distribution and access will be monitored.

Please refer to Goal One in the Quality Assurance section of the waiver request. In general the Agency plans to monitor the number of providers (private and clinic) that see beneficiaries, hours of operation, waiting times, complaints as well the number of new providers enrolled in the program, and the number of services that are provided. Once baseline data is obtained, it is anticipated that there will be indicators of the areas that are most at risk for access problems.

(3) Please explain how geographic distribution of participating

family planning providers will be tracked to facilitate active recruit of new providers or to expand services to ensure that the program produces demonstrable outcomes for the targeted population.

Participating providers will be tracked on a county basis as compared to the Medicaid population in the county. Areas with low provider/recipient ratios will be targeted.

Attachment 1	Care Coordinator Curriculum
Attachment 2	Risk Assessment Tool
Attachment 3	Notices
Attachment 4	Application
Attachment 5	Preliminary Evaluation
Attachment 6	Replacement Paaes

Attachment 1

Family Planning Care Coordination Training

lst Day

8:30 - 9:30	Overview of 1115 Family Planning Waiver
9:30 - 10:00	The Changing Role of Public Health
10:00 - 10:15	Break
10:15 - 10:45	Program Outreach to Patients and Providers
10:45 - 11:30	Bio-Psychosocial Model of Family Planning Care Coordination
11:30 - 11:45	Historical Progression of Birth Control
11:45 - 12:00	Philosophy of Birth Control
12:00 - l:oo	Lunch
1:00 - 1:30	Cultural Issues Related to Birth Control
1:30 - 3:00	Overview of Birth Control Methods/Clinician's Persuective
3:00 - 3:30	Principles of PT+3 at Work in the Famil Planning Clinic
3:30 - 4:00	Working with the Private Provider in Coordinatina Patient Care
4:00 - 4:30	Overview of the Dav - Question and Answer Period

2nd Day

8:30 - 9:30	Grouu Exercises
9:30 - 10:30	Documentation
10:30 - 10:45	Break
10:45 - 11:45	Legal Asuects of Program
11:45 - 12:45	Lunch
12:45 - 1:45	Record Keeping
1:45 - 2:00	Evaluations, CEUs

Attachment 2

Department of Public Health Family Planning Risk Assessment

Patient's Name:_____ Medicaid #:_____ Date:_____

Medical Provider:_____ FPCC:_____

Below are **risk** factors that may indicate the need for family planning care coordination services (please check relevant response(s) and provide additional comments where appropriate):

Identification of a **risk** factor in Column **A** places a patient at high-risk for **an** unintended pregnancy and indicates a need for care coordination. Identification of **a** risk factor in Column B may indicate a need for care coordination. Each patient should be assessed individually. The FPCC's professional judgment should be used to make the final decision as to follow-up needs of the patient

Column **A**

1. Substance abuse (alcohol, street drugs, prescribed medications) ___
2. Education/communication/language barriers___
3. Mental impairment/illness___
4. Suspected domestic violence___
5. Non-compliant with medical care ___
6. Inadequate transportation to medical care ___
7. Multiple sex partners ___
8. HIV/STDs___
9. Lack of family/social support system ___
10. Four or more pregnancies___
11. Interpregnancy intervals of <2 years ___
12. History of elective abortions ___

Column B

1. History of premature births___
2. Previous unintended pregnancy___
3. Low birth weight babies___
4. Fetal deaths___
5. History of spontaneous abortions ___
6. Serious illness/injury/disability___
7. Genetic factor(s) (specify)

Patient is assessed to be ___high-risk low-risk
Patient accepted care coordination ___
Patient refused care coordination ___

COMMENTS:_____